RIVERTON/ZENITH FAMILY HEALTH PATIENT INFORMATION

Please Print & Complete All Fields

PATIENT INFO

Name: (First) ____________ (MI) ______ (Last) ____________ Sex: [ ] M [ ] F

Date of Birth: _____/_____/_____ Marital Status: [ ] S [ ] M [ ] W [ ] D [ ] Other__________

SSN: _____-_____-_______ Email: ____________________ Can we email you? [ ] Yes [ ] No

Address: ____________________ (City) ____________ (State) ______ (Zip) ________

Billing Address (If different from above): ____________________ (City) ____________

(State) ______ (Zip) ________

Home Phone #: (_____) _______-_________ Cell Phone #: (_____) _______-_________

Preferred Phone Number: [ ] Home [ ] Cell [ ] Work

Can we leave you a voice message? [ ] Brief [ ] Detailed Do you accept texts? [ ] Yes [ ] No

Preferred Time to Call: [ ] Morning (6 am – 12 pm) [ ] Afternoon (12 pm – 4 pm) [ ] Evening (4 pm – 9 pm)

Pharmacy Name: ____________________ Location: ____________________

Race: [ ] White [ ] Hispanic [ ] African American [ ] American Indian [ ] Asian [ ] Pacific Islander [ ] Other

Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Rather not Report

Language: [ ] English [ ] Spanish [ ] Indian [ ] Russian [ ] Other __________ Sign Translator? [ ] Yes [ ] No

Employer: ____________________ Emp. Status: [ ] FT [ ] PT [ ] Other__________

Work Phone #: (____) _____-________

FINANCIAL RESPONSIBLE PARTY FOR HOUSEHOLD

Name: (First) ____________ (MI) ______ (Last) ____________ Relation: __________

Date of Birth: _____/_____/_____ SSN: _____-_____-_______ Phone #: (____) _____-________

Address: ____________________ (City) ____________ (State) ______ (Zip) ________

EMERGENCY CONTACT

Name: ____________________ Phone #: (____) _____-________ Relation: __________

Address: ____________________ (City) ____________ (State) ______ (Zip) ________

INSURANCE

Primary Insurance Co: ____________________

ID #: ____________ Group #: ________

Policy Holder Name: ____________________

Policy Holder DOB: _____/_____/_____

Policy Holder SSN: _____-_____-_______

Relation to Patient: ____________________

Secondary Insurance Co: ____________________

ID #: ____________ Group #: ________

Policy Holder Name: ____________________

Policy Holder DOB: _____/_____/_____

Policy Holder SSN: _____-_____-_______

Relation to Patient: ____________________

Please provide address of Policy Holder if different than patient.

Policy Holder Address: ____________________

____

Policy Holder Address: ____________________

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PRACTICE INFORMATION

How did you hear about us: [ ] Provider Directory [ ] Physical Referral [ ] Phone Book [ ] Friend/Relative

[ ] Internet [ ] Pony Express Days [ ] Building Sign [ ] Established Family [ ] Other__________

VFC (Vaccines for Children) Program Eligibility

Does your child's insurance cover immunizations? [ ] Yes [ ] No

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____

Signature of Patient Today's Date

____

Signature of Responsible Party (if other than patient) Relationship to Patient

Riverton and Zenith Family Health *Office Policy*

FINANCIAL POLICY

I. RESPONSIBLE PARTY

a. RFHC will gladly submit claims to your insurance for the services provided. However, charges accrued on the account are *your responsibility*. You will be expected to follow up on any unpaid or incorrectly paid charges, regardless of insurance coverage. We will be happy to assist you in any way we can, but ***you are ultimately responsible for timely payment of your account.*** *You are responsible for payment-in-full if your insurance company does not pay us within 90 days.*

b. You will be responsible for charges accrued by children who have turned 18 until such time as you notify RFHC in writing, prior to services being provided, that you no longer accept financial responsibility.

II. BILLABLE SERVICES

a. RFHC will charge for all appointments and supplies used. We will also charge for patients who are not scheduled (i.e., siblings of a scheduled patient) that the physician is asked to see.

b. RFHC will charge for all follow-up services. The same resources (staff, room, supplies, physician time, etc.) are used for the follow-up visit.

c. Occasionally a patient will be scheduled for one type of service but the physician may diagnose and treat another problem in addition to the scheduled service. When appropriate, RFHC will charge for the additional service. Some insurance companies will not cover both services, which may result in denial or higher copay.

d. RFHC reserves the right to charge $50 for missed appointments. This charge will not be billed to your insurance company, but will be your responsibility. To cancel existing appointments, please notify our office at least 24 hours prior to your scheduled appointment time.

III. **PAYMENT DUE AT TIME OF SERVICE**

a. If you have insurance coverage, all co-pays, co-insurance, and deductibles are due at the time of service. An additional $20 fee will be added if you fail to pay your co-pay at the time of service.

b. A $50 deposit is due at each appointment check-in for self-pay patients. Payment in full is due from self-pay patients at the time of service. A discount will be given when charges are paid in full on the date of service.

c. RFHC reserves the right to charge a statement fee for any amounts that become past due and require additional statements to be sent.

d. RFHC may present charges to you by written statement following a visit. If we do this, we expect that each charge will be paid in full by return mail the first time it is presented to you. We may send you statements and reminders of charges, or we may call you about the same. By accepting our services, you are consenting to receive these communications.

e. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance, this is a matter between you and your insurance company. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved.

IV. INSURANCE COVERAGE

a. It is your responsibility to provide accurate insurance information to RFHC at the time of service.

b. RFHC will create and submit claims to your insurance on your behalf. However, we reserve the right to refuse insurance and collect payment in full from you (i.e., insurance information provided after claim filing deadlines, etc.).

c. It is your responsibility to verify benefits under your plan. You will also be responsible for amounts not paid by your insurance for any reason, unless the amounts are covered under RFHC's contractual agreement with insurance.

d. RFHC must, under federal law, accurately report the services provided to you. Your insurance company may not pay for all services received. RFHC cannot change the service or diagnosis codes (unless they were initially reported incorrectly) in order to make a service "fit" your insurance plan benefits. We must report the exact services provided and the exact reason for providing them.

e. Your signature on this policy authorizes RFHC to release health information to insurance carriers when necessary for payment, and directs them to remit payment directly to RFHC (assignment of benefits).

V. CREDITS

a. Any insurance credits or over-adjustments will be returned to the appropriate insurance company.

b. Any patient credits or overpayments will first be used to pay past-due balances, including those which may have been referred to an outside collection agency.

c. If patient balances have been resolved, patient credits will be returned. Please allow 4-6 weeks for processing. Smaller credits (generally under $25.00) may be left on the account to be used for future co-pays and/or deductibles.

VI. COLLECTIONS

a. By signing this form, you agree to receive texts concerning the billing status of your account.

b. Your account may go to collections for the following reasons that include but are not limited to:

i. Invalid patient demographic information (address, phone, etc.) which prevents us from contacting you regarding your account.

ii. Failure to provide timely, accurate insurance information.

iii. Failure to pay patient balances.

iv. Failure to follow through with statement discrepancies, insurance denials or any other items on your account.

v. Failure to follow through with other correspondence from RFHC.

c. RFHC makes every effort to work with you to keep your account out of collections. However, in the event that your account is referred to a third party debt-collection agency, you will be responsible for the balance of the account in addition to a 30% collection fee and any other amounts allowed by law (interest, court costs, attorney's fees, etc.), as allowed by Utah Code Annotated section 12-1-11.

d. Utah Law requires health care facilities to provide patients and/or responsible party(ies) with notice, by certified mail, priority mail, or text message, 45 to 60 days prior to placing any delinquent balance with a collection agency or reporting and delinquent balance to any credit bureau. Such actions may negatively impact the responsible pary(ies) credit score. A $15.00 fee will be charged if any such notice is sent.

MEDICAL RECORDS/ HIPAA COMPLIANCE ACKNOWLEDGEMENT

I. Our written Notice of Privacy Practices provides detailed information on how we may use and disclose your protected health information. According to HIPAA provisions, you have the right to review a copy of this notice prior to signing this form. You also have the right to receive a printed copy of the privacy notice if you so desire, and is available upon your request. If necessary, a legal guardian or authorized representative should sign. This clause authorizes the doctor to release any medical information that may be used for the following purposes: Treatment, Payment, and Operations, and at times when the doctor deems it necessary in order to ensure the best medical care on your behalf. We are required by law to maintain your confidentiality of any health information that identifies you. We are committed to protecting your privacy. This is an ethical and legal obligation that we owe to our patients. Your signature is required to be compliant with HIPAA. Any person that receives these medical records is not authorized to release any of the information obtained by this authorization to any other person or organization without a further authorization signed by you for the release of this information. A fee will be charged to the patient or third-party requesters for copies of medical records.

PRESCRIPTION

I. All prescriptions for controlled substances, antibiotics, new medications not formerly given by RFHC, and established medications require an office visit. The provider will prescribe enough medication to last until they would like you to follow up. When you pick up your last refill from your pharmacy, please call our office to schedule your follow-up appointment.

II. By signing below, you grant RFHC/ZFHC permission to view your prescription history from external sources.

Thank you for trusting Riverton/Zenith Family Health Center with your care. We are dedicated to making your experience a positive one. Please do not hesitate to contact us with any questions regarding your account, payment options, or financial responsibilities.

[ ] I have read and understand the above policies, and I will be financially responsible for the following patient:

______________________ PRINT Patient Name	____/____/____ Patient's Date of Birth
______________________ PRINTED name of Legal Guardian, if other than patient	______________________ Relationship to Patient
______________________ Signature	____/____/____ Today's Date

CONFIDENTIALITY RELEASE AUTHORIZATION

I, ______________________________ Date of Birth______________
(Name of Patient, please print)

Give permission for my

[ ] Test Results

[ ] Patient Records

to be disclosed to ____ at their request.
(Name of recipient, please print)

____
(Relationship to Patient)

Patient Signature______________________ Today's Date____________

ARBITRATION AGREEMENT

Article 1 **Dispute Resolution** By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 **Definitions**

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.
B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.
C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.
D. The term "Patient" or "you" means:
   (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
   (2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 **Dispute Resolution Options**

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
   (1) working directly with each other to try and find a solution that resolves the Claim, OR
   (2) using non-binding mediation (each of us will bear one-half of the costs); OR
   (3) using binding arbitration as described in this Agreement.

You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
C. Arbitration - Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 **How to Arbitrate a Claim**

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail, it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
   (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
   (2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly- Selected Arbitrator, either or both of us may request that a Utah court selects an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.
E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Part") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 **Liability and Damages May Be Arbitrated Separately** At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly-Selected Arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 **Venue / Governing Law** The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre-litigation panel review requirements. The arbitrators will apportion to fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 **Term / Rescission / Termination**

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).
C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 **Severability** If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 **Acknowledgement of Written Explanation of Arbitration** I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having it heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 **Receipt of Copy** I have received a copy of this document.

PROVIDER: ZENITH & RIVERTON FAMILY HEALTH CENTERS

BY: ______________________________
Signature of Physician or Authorized Agent

Name of Patient (Print) ______________________________

______________________________ ___/___/___
Signature of Patient or Patient's Representative Date

Please return this sheet to your Provider's Medical Assistant

Patient Name: ______________________________

Please indicate below if you have had problems with any of the following conditions in the recent past:

	YES	NO		YES	NO		YES	NO
ALLERGY			Epistaxis (nose bleeds)			Joint swelling		
Postnasal drip			Hearing loss			Leg cramps		
Sneezing			Changes in voice			Sciatica		
Runny nose			Sore throat			Osteoporosis treatment		
Scratchy throat			Ringing in ears			Fracture		
Itchy eyes			Sinus pain			Carpal tunnel syndrome		
Ear fullness			**FEMALE REPRODUCTIVE**			**NEUROLOGY**		
Sinus congestion			Vaginal dryness			Distal extremity pain		
RESPIRATORY			Cramping			Dementia		
Stop breathing with sleep			Irregular periods			Confusion		
Asthma			Amenorrhea (absent periods)			Restless legs		
Shortness of breath			Heavy periods			Tremor		
Chest congestion			Dyspareunia (painful sex)			Headaches		
Cough (persistent)			Dysmenorrhea(painful period)			Tingling or numbness		
CARDIOLOGY			Infertility			Seizures		
Heart murmur			Frequent yeast infection			Insomnia		
Dizziness			Pelvic pain			Memory loss		
Chest pain			Breast pain or lump			Dizziness		
Irregular heart beat			Nipple discharge			Gait abnormality		
Edema (leg swelling)			Contraception			**OPHTHALMOLOGY**		
Varicose veins			Abnormal vaginal discharge			Spots in vision		
CONSTITUTIONAL			Hot flashes			Flashes of light		
Sleep disturbance			**MALE REPRODUCTIVE**			Eye redness		
Night sweats			Testicular pain or lump			Photophobia (pain with lights)		
Weight gain (unexplained)			Difficulty with erection			Eye irritation		
Loss of appetite			Diminished sex drive			Eye drainage		
Fever			Penile discharge			Blurring of vision		
Weakness (generalized)			Contraception			Seasonal eye symptoms		
Weight loss (unexplained)			**GASTROENTEROLOGY**			Diminished vision		
DERMATOLOGY			Melena (black stool)			**PSYCHOLOGY**		
Itching			Gas			Emotional lability		
Lesions			Nausea			Difficulty paying attention		
Fungus nails/skin			Heartburn			Depression		
Warts			Vomiting			High stress level		
Rash			Abdominal pain			Sleep disturbances		
Moles			Difficulty swallowing			Suicidal thoughts		
Lumps			Diarrhea			Eating disorder		
Dry skin			Constipation			Mental or physical abuse		
Hives			Blood in stool			Anxiety		
Acne			Hemorrhoids			**UROLOGY**		
Skin cancer			**HEMATOLOGY/LYMPHATIC**			Dysuria (pain with urination)		
ENDOCRINOLOGY			Excessive bleeding			Urgency to urinate		
Polydipsia (excess thirst)			Swollen glands			Blood in urine		
Polyuria (excess urination)			Fatigue			Frequent urination		
Weight loss			Loss of appetite			Incontinence		
Sleep disturbance			Varicose veins			Recurrent UTI		
Cold intolerance			Easy bruisability			Nocturia (urination at night)		
Heat intolerance			**MUSCULOSKELETAL**			**OTHER**		
Diabetes			Back pain					
EAR NOSE & THROAT			Myalgia (muscle pain)					
Ear pain			Weak muscles					
Runny nose			Chest wall pain					
Cold			Joint stiffness					
Cough			Joint pain					